FOR STATE HEALTH DEPT.

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages I and 2 with the State Department of 00 Health prior to burial, cremotion, or removal, and in any event within 72 hours ofter dath-

necessory, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shauld be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page O DEPUTY MERCAL EXAMINER: This certificate should be executed within 24 hours ofter death. If any delay is

0311

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

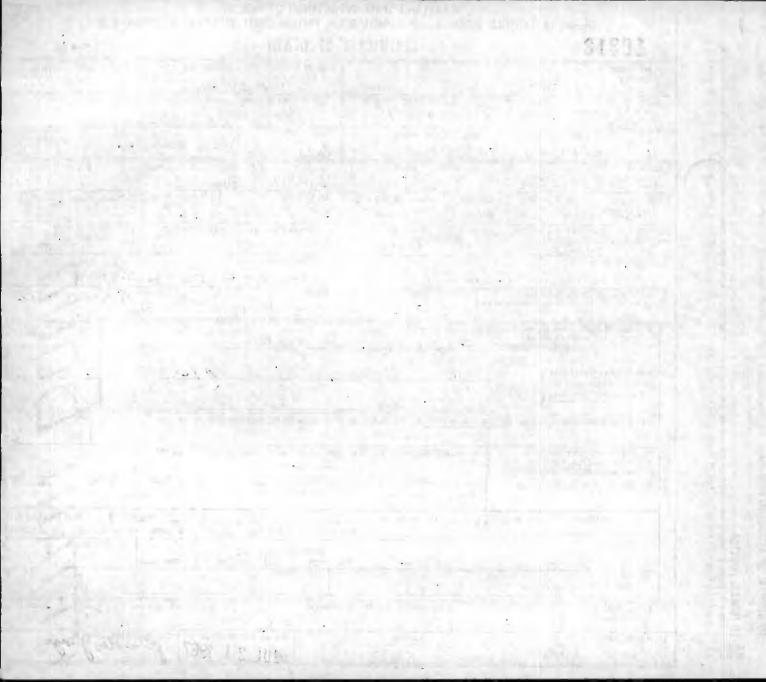
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

		LUGIL MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	0311
	(COUNTY WURGESTER MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution) Reside o. STATE 50 COOCLOGIC (MUST)	MDV
		o. CITY OR TOWN III autiside corporate Limits. Write BURAL and give nearest fown DCF.AN CITY LENGTH OF STAY IN 16	C. CITY OR TOWN (If outside corporate limits, write RURAL and gi	30.4
0		i. NAME OF HOSPITAL OR'INSTITUTION (If not in hospital, give street oddres) cean Park Motel Ocean City, Maryland	d STREET ADDRESS 506 Cedarcroft Road	e is residence on a farm? yes \ no \
)	-	VAME OF DECEASED Type or print) 6. COLOR OR RACE WIDOWED DIVORCED DIVORCED	Last 4. DATE Month OF DEATH 8. DATE OF BIRTH 9. AGE (In years Ist UNDER Months Wrs.	Doy Year 7 1967 R LYEAR IF UNDER 24 HRS. Doys Hours Min.
		USUAL OCCUPATION (Give kind of work done no not of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11 RIRTHPLACE (State or foreign country) 12. (OUNTRY?
		FATHER'S NAME Wm. Brooks (Westley)	14 MOTHER'S MAIDEN NAME Laura Brown Brooks	
	IS. (Ye:	was deceased ever in u.s. armed forces? 16. social security no. 218-16-1510	Husband Same	
		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Mar Collapse	ONSET AND DEATH
		Conditions, if ony, which gove tise to immediate cause (a),	al Infaction	wies
		stoting the underlying couse lost. DUE TO Co Co Co Co Co Co Co C	Coxic Cideoresulas	Irace years
2	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED? YES NO
	L CERTIFICATION	200. EXTERNAL CAUSE WAS PRIMARY □ OF CONTRIBUTING □ CAUSE OF DEATH.	(Enter nature of injury in Port I or Port II of Item 18.)	
	MEDICAL		CE OF INJURY (Home, form, 20f. (City or town) (City, street, office bldg , etc.)	ounty) (Stote)
		21. I certify that I took charge of the remains described above, he death resulted fram. Natural causes Accident . Suice		and in my apinion
		SIGNATURE Jonald Cama	M_D ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	22. DATE SIGNED
2	230	EXAMINER'S J. DONALD CAPIZA A BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	10 lauricum Channel Egyothice and ty	(County) (Stote)
	230.	REMOVAL (Specify) Burial 7/24/1967 Loudon Park Ce	emetery Baltol Maryland	
	Se Se	ugenia K. Seitz 5209 York Road Sitz Funeral Home Relto. Md. 21212	250. REC'D BY REGISTRAR 25b. REGISTRAR'S DATE JUL 25 1967	SIGNATURE PLAS JUDGE
1				

VR A15ME (5)

and the same of the 7. 7. 111 10 506/14 /C Sparle & the state of the state of - 1773-1-7. readers that conduct

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10312 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death death. pun 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission filled in by the funeral I. PLACE OF DEATH o. COUNTY BECESTE MARYLAND Sapers. Pages 1 r. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO S NAME OF 4. DATE event wit First Middle Month Year carbon campletely DECEASED OF 196/ DEATH (Type or print) IF UNDER 1 YEAR 9. AGE (In years 7. MARRIED NEVER MARRIED remove lost birthdoy) in any WIDOWED DIVORCED YIS. and 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of warking life, even if retired) COUNTRY? CEL BETH. STEEL MOTHER'S MAIDEN NAME 13. FATHER'S NAME 0 burial, crematian, or remaval, signed by the attending phy burial-transit permit. Then GEDEGE FELH ZIA E 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (0) be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been be detached far use as the State Dept. af Health prior ta WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour o.m of work TERMINAGE 21. I certify that (I) (this hospital) attended the deceased fram. , that (1) (we) last director, page 3 shauld shauld be filed with the 67, and that death accurred at/13 PM, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE **ATTENDING** STAFF M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL Page 4 may NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION, DATE THEREOF (County) (Stote) REMOVAL (Specify) I GERMANHILL RO. BA CEM. 250. REC'D BY REGISTRAR REGISTRAR'S SIGNATUR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



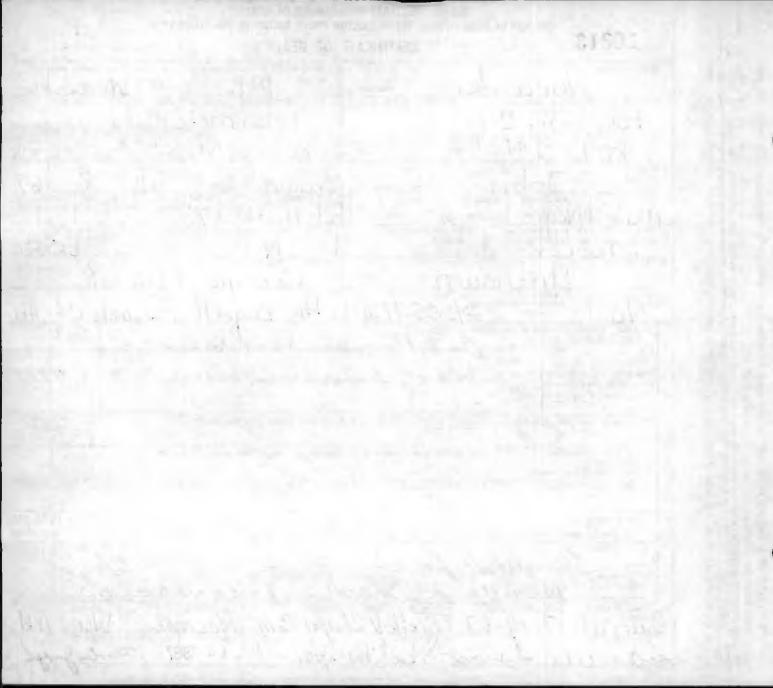
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10313

CERTIFICATE OF DEATH

10913

E COLE		CONTINUE OF PERIOD
r death readh		PLACE OF DEATH O. COUNTY O. STATE MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) b. COUNTY O. STATE MARYLAND
haurs ofter by the fig.		b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)
filled in pagers.		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 807-2 nd S+, VES NO NO RESIDENCE ON A FARM? YES NO NO RESIDENCE ON A FARM? YES NO NO RESIDENCE
G PHYSICIAN: The law requires that the death certificate be executed within 24 haurs ofter the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in but the fur detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 to Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours often		NAME OF DECEASED (Type or print) NAME OF DECEASED (Type or print) NAME OF DEATH JULY 8 1967
execute and comp remove any eve	S.	Male Negro WIDOWED DIVORCED Feb. 1, 1888 - Striftday) Months Doys Hours Min.
ate b≡ ex ician ond lease rem and in an	dur	. USUAL OCCUPATION (Give kind of work done in mount of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACY (County & Store, or foreign country) 12. CITIZEN OF WHAT COUNTRY 7 LS A
certificate t g physician Then please moval, and		FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME GEORGIE Ella?
ne dw⊡th cer ottending p permit. The ion, or remo	15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 18. INFORMANT 18. INFORMANT 19. INFO
that the an. by the c ransit p		18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) PART I. DEATH ONSET AND DEATH
equires thr physician. signed by burial-trar burial, cre		Conditions, if ony, which gove is to immediate couse (a), (b) Charenary Arterial Selvaseis 3-44RS
e law rec trending F as been s os the b prior to b		stoting the underlying couse DUE TO (c)
VSICIAN: The law re ospital or ottending certificate has been hed for use as the otten of Health prior to	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(b) 19. WAS AUTOPSY PERFORMED? YES NO
HYSICIAN hospital c s certificat oched for spt. of Hec		206. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 208. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
C HOSPITAL OR ATTENDING PHYSICI Page 4 may be retained by the hospit 5 FUNERAL DIRECTOR: After this certificatior, page 3 should be detached should be filed with the State Dept. of	MEDICAL	20c. TIME OF INJURY Manth, Doy, Year Hour o.m. Pm. 19 20d. INJURY OCCURRED Not While of work 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
CO HOSPITAL OR ATTENDING PH Page 4 may be retained by the h O FUNERAL DIRECTOR: After this director, page 3 should be detoo		21. I certify that (1) (this haspital) attended the deceased fram 4/18, 1963, to 7/8, 1962, that (1) (we) last saw the deceased alive an 1967, and that death accurred at 1934M, fram causes and an the date stated above.
OR ATTENI be retoined DIRECTOR: A ge 3 should led with the		220. SIGNATURE ATTENDING PHYS. DIRECTOR STAFF PHYS. 226. DATE SIGNED
TO HOSPITAL Poge 4 may b TO FUNERAL director, pag should be file	02-	NAME (TYPE) NEVILLE A. BARON JOCOMOKE, MD
Poge To Flu	130	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY, 23b. OCCATION (City of Town) (County) (Stote) REMOVAL TSpecify) 7-12-67 Tindley Chapel Cem. Hocomoke Work. NYd. WORRAL DIRECTOR 25b. REGISTRAR'S SIGNATURE
VR A15 (4) 25M 1/67	1	Touch Va, DATE JUL 1 4 1967 yourse Juse



10314

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #8 Film #6391 8/2/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10314

	J. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution, Resident	e before admission) , /
1	O. COUNTY DR. O. G. S. T. E. R. MARYLAND	O STATE CHILCOT COUNTY MA	mand
1	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corparate limits, write RURAL and give	neorest town)
1	write RURAL and give nearest town) CEEAU (174) 2 months	Chinenteense .	133
1	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE
	1001 PhILA. AVE. OCEAN CITY,	03 Smith Stree	YES NO
		2 PENTER DEATH July 26	Doy Year
	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED 8	DATE OF BIRTH 1899 9. AGE (In years lest birthday) Months Months	YEAR IF UNDER 24 HRS Doys Hours Min.
	100. USUAL OCCUPATION (Give kind of work dane during most of working life, even if refired) 10b. KIND OF BUSINESS OR INDUSTRY		ZEN OF WHAT
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
	WILLIAM CARPENTER	Namel Willia	45
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. III (Yes, no, ar unknown) (If yes give war or dates of service)	NFORMANT: Le Address	
	18. CAUSE OF DEATH (Enter only one couse per live for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Was Callanse	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO VILLOS OF	a andruction	Milie
	rise to immediate cause (a), stating the underlying cause lost.	orice Culmilarilar Di	years
		edie man acame can	19. WAS AUTOPSY
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE CONDITION GIVEN IN PART ((a)	PERFORMED? YES NO
	E CAUSE OF DEATH.	Enter nature of injury in Part I or Part II of item, IB.)	
		E OF INJURY (Hame, form, 20f. (City or town) (Cou pry, street, office bldg., etc.)	nty) (Stote)
	21. I certify that I took charge af the remains described above, hel	d an Autopsy 🔲, Inspection 💢, Inquiry 💢,	and in my apinian
1	death resulted fram: Natural causes 💢 , Accident 🔲 , Suicident		
	ACTUAL 100 Como	CHIEF MEDICAL EXAMINER	
	SIGNATURE DONGLA CAMO	_M.D. ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
	EXAMINER'S TOPOLACE CAPRA	DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	1126/61
	230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR C Burial 7-30-67 Daiseu (emete	C1	(County) (State)
	Salver Funeral Home, (hincoteague, Virgi		GNATURE

The British Co. a the state of the state of the Se we a second of the second o 1 3 5 The state of the s THE PERSON carlinal regulations, you assume that white the State Department of

Health prior to burial, cremation, ar removal, and in any event within 72 haurs after death

8-10-67 MARYLAND STATE DEPARTMENT OF HEALTH Items 18&Film W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10315

1. PLACE OF DEATH O COUNTY	2. USUAL RESIDENCE (Where deceased lived, if institution Reside o. STAY). b. COUNTY	
	RYLAND (1) C	
b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY white RURAL and give negrest take)		^ /
Licean and I was		nd /
d: NAME OF HOSPITAL OR INSTITUTION (It nat in haspital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
BAMILTON HOTEL	17322 District PKWY	YES NO
3. NAME OF DECEASED (Type or print) EII-W OII	ASTIC SEATH JULY	26 1967
S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIE DIVORCI	lost birthday Months	Days Hours Min.
165 USUAL OCCUPATION Give kinds of Actions (10b. KIND OF BUSINESS OR INDUSTRY)		OUNTRY?
13. FATHER'S NAME	14 MOTHER'S MAJOHN NAME DILI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, anythnown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO.	EUGENE CASTE (HUSBAND) SA	me
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:	D I	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (o)	V/84M/5VY/M/9V	OHOET AND DEATH
Conditions if any which gave	h and a	77 1
(b) Ethyllem, it sets to immediate cause (a), (b)	Acute	Unknown
stating the underlying cause DUE TO		450
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RE	ELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	PERFORMED? YES NO
PRIMARY 🗆 or CONTRIBUTING 🗅 CAUSE OF DEATH.	OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour c.m. 20d INJURY OCCURRED While at work at work	20e, PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)	ounty) (State)
21. I certify that I took charge of the remains described a	above, held an Autapsy , Inspection , Inquiry	and in my apinian
deoth resulted from: Natural couses 🔼 , Accident 🗌	, Suicide , Hamicide , Undetermined manner [-
ACTUAL SIGNATURE AND AMERICAN - D	CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
EXAMINER'S NAME (Type) - J. (OW/VSENDS)	JR. DEPUTY MEDICAL EXAMINER OF MICHAEL STATE OF THE STATE	1967
	METERY OR CREMATORY 23d LOCATION (City or Town)	(County) (State)
BURIAL 7/29/67 CEDAR HI	ILL CEMETERY SUITLAND, PRINCE	GEORGES MA
24 EUNION DIRECTOR ADDRESS	HOME 250. REC'D BY REGISTRAR 25b. REGISTRAR'S	SIGNATURE

1967

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MARYLAND STATE DEPARTMENT OF HEALTH

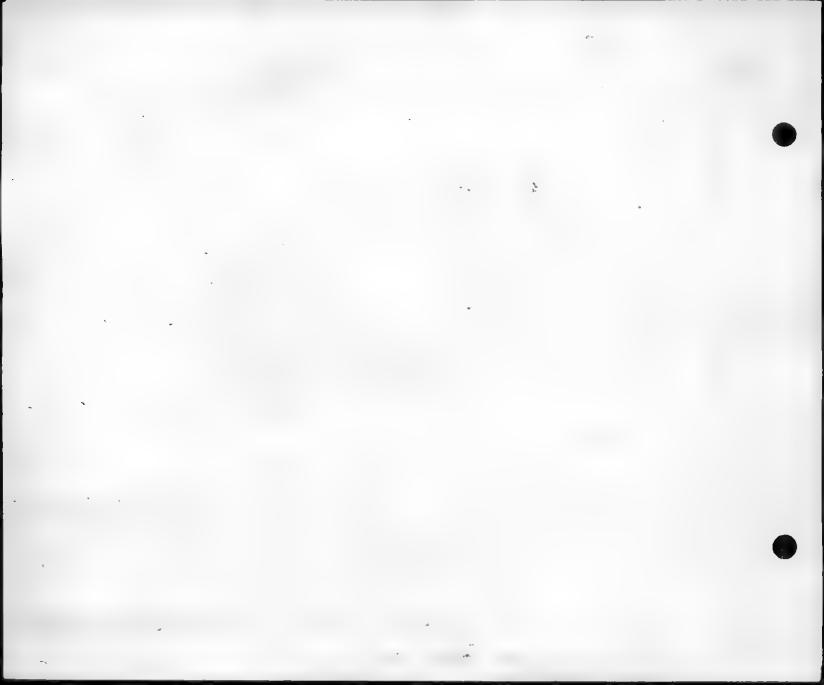
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE		10316	MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	
EALTH ABPT.		LACE OF DEATH		7 USUAL RESIDENCE (Where deceased lived	
5 7 8 × 2	1	WORCES TE	R. MARYLAND	O. STATE VIRGINIA	6 COUNTY ACCOMACK.
d 3		(ITY OR TOWN (I outside carporate limits write RURA, and gove heatest town)	c LENGTH OF STAY IN 16	CLITY OR TOWN (f outside carparate mits,	write RURAL and give nearest town)
y di	1	CEAN CITY	3 WKS	KELLER.	-7
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es 1 form form te D	L	DEBAN FOOT	DE THE	PO BOX: KIZL	LEK, WH YES NO P
we Pogrith		AME OF First POWNIE	Middle Col	LOST 4. DATE OF DEATH	Month Pay Year 7
2 with	5	EX 6 COLOR OR RAKE	7 MARRIED NEVER MARRIED WIDOWED DIVORCED	8 DATE OF BIRTH May 27, 1952 Wist br	year IF NDER 1 YEAR IF UNDER 24 HRS. Manths Days Hours Min.
24 haurs in Item 1 s Office s land 2 fter deat	10a dur	JSUAL OCCUPAT ON (Give kind of work dane ig most of work in life, even if retired)	106 KIND OF BUSINESS OR INDUSTRY	1) BIRTHP, ACE (State or fare gn country)	12 CHIZEN OF WHAT COUNTRY? USA.
within 24 percil in xominer's ile poges hours off		FATHER'S NAME CHECKER	CONSTRUCT.	14. MOTHER'S MAIDEN NAME HATTIE. CON	QUIEST.
		WAS DECEASED EVER IN U.S. ARMED FORCES? , no. ar upwnawn) (If yes give war ar dates af		INFORMANT SMITH,	Address WACHAPREAS
id lle mxecut rd 'penlling Chief Medico rromsit permi		18. CAUSE OF DEATH (Enter only one couse PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c	HADH UNIA	700	INTERVAL BETWEEN ONSET AND DEATH
we we the the ringle		1 X 1 8 DUE TI Conditions, if any, which gave 1	Danielle	ist PULMOVARY	EDIFMA MINDUTES
rificate sl		stating the underlying cause (a), but To but	11000111 101	<i>ie</i>	KINUTTER
Is certific. Writh forwold.	ATION		ATRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART	1 (a) 19 WAS ANT SPRY PERFORMED? YES NO
ER: The certifica and be as howeld be not ar re-	L CERTIFICATION	200. EXTERNAL CAUSE WAS PRIMARY ID OF CONTRIBUTING □ CAJSE OF DEATH	FRIL OFF	(Enter nature of Injury in Port I or Port II of Ger SURF BOARO	MBLES to Swim
CAMIN te thm pe 4 shi your filk age 3 s emotros	MED CAL	20c TIME OF INJURY Manth, Day 1 Year 10 15 pm 1/3/6)19	White at wark at wark	ACE OF INJURY (Hame form, tory, street office big, etc.)	CITY WORRSTER !
Page Page Page Page Page Page Page Page		21 I certify that I took charge	of the remoins described above, he	eld an Autopsy . Inspection .	Inquiry , ond in my opinio
se ex krtor ned f		death resulted from latural	co ses , Accident , Suid	c de , Homicide , Undeterm	ined monner
Mea Slea dire etoi DIR		ACTUAL SIGNATURE	OXALU.	M.D. ASSISTANT MEDICAL EXAM NER	22. NATE SIGNED
Cessary e funeral may be r		EXAMINER'S NAME Type)	DR LOWITZ	A LESCHOOL STANLINER CANONINER	md 7(3(6)
TO DEN netessa the fun 5 may TO FUNE To a th	230	F R AL CREMATION, 236 DATE THER TOWN VALUE OF Y) 7-08-	EOF 23 NAME OF CEMPTERY OR 60 7 Red Hill	CREMATORY 23d LOCAT ON C	ty or Town' ((Inty) (State)
VR A15ME (5) 6M 1/67	24	THERA DECTOR HILLANDE	acconac	79 250 REC D BY REG STRAR	25b REGISTRARS S GNATURE
DM 1/0/	7	- During		1 Che- DATE JUL 6 196	7 Icharles Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10317 I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). o. COUNTY WORCESTER b COUNTY MARYLAND delov State Department b CITY OR TOWN (If outside corporate im b C LENGTH OF STAY N 16 outs de carporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) d NAME OF ROSPITAL OR INSTITUTION (If not in hospital, give street address) S RESIDENCE ON A FARM? forworded to the Chief Med.col Examiner's Office along with form Give Pages FISHING NO F NAME OF First Midd e DATE Month Dov Year DECEASED OF 19 6 (Type or print) DEATH podes land 2 with S SEX DATE OF BIRTH 9 AGE (In years IF JADER 1 YEAR JE UNDER 24 HRS NEVER MARRIED eath lost birthday) Months Hours DIVORCED IDo USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? 72 hours ofter pencil 13. FATHER'S NAME permit. File IS WA DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes no or inknown) (If yes give war or dates at service) pending event within 18 CAUSE OF DEATH (Enter only one cause per ine INTERVAL BETWEEN buriol-tronsit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o' This certificate should writing the word DUE TO λuo Conditions, Lony which gove nse to immediate couse (o), .= DUE TO D stoting the under ying couse puo lost be used WAS AUTOPSY PERFORMED? PART IF OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) removal, YES A HO pe 200 EXTERNAL CAUSE WAS 2Db DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1, of term 18.) 3 should PRIMARY Or CONTRIBUTING Б 4 should STEAL EXAMINER: CAUSE OF DEATH cremation, 20c TIM. OF INJURY Month, Day Year 20d INJURY OCCURRED 2De PLACE OF INJURY (Home form (City or town) (County) (Stote) Not While factory, street office bidg etc.) moy be retoined for your FUNERAL DIRECTOR: Poge 196 Poge at work FISHING BUST 21 I certify that I taok charge of the remains described above, held on Autopsy [Inspection Inquiry and in my opinian death resulted from: Noturol causes 2 Accident Suic de Undetermined manner Ham+cide DATE SIGNED Heolth prior the funerol DEPUTY DEPLTY MEDICAL EXAMINER NAME (Type) Address (Street city town or county) 23d LOCATION IC by as Tawret 2Sa REC'D VR A15ME (5) 6M 1 67



MADVIAND STATE DEPARTMENT OF HEALTH

MAKTLAP	ID STATE DEPARTME	NI OF REALIR	
DIVISION OF VITAL RECORDS,	301 W. PRESTON STRE	ET, BALTIMORE, MARYLAND	2120

FOR STATE HEALTH DEPT.

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in pencil in Item 18 Give Poges 1

10215

MEDICAL EXAMINER'S CERTIFICATE OF

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1 PLACE o COU	OF DEATH	2 USUAL RESIDENCE (Where deceosed lived, if institution Reside	nce before admission)
	MARYLAND MARYLAND	1/1/2	OR
wy	ON TOWN (If outs de corporate limits, c LENGTH OF STAY IN 16 RDIRAL or 3 give headest told) Alequille 3043	C CMY OR TOWN (If outside corporate limits, write RURAL and g v	va neorest town)
d ₂ NAN	AE OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress)	d STREET ANDRESS	e IS RESIDENCE
RI	Box 246	RI BOX 246	ON A FARM? YES NO
		VIS DATE OF DEATH JUY S	Doy Year
S SEX	VI COLOR OR RACE 7 MARRIED NEVER MARRED DIVORCED DIVORCED	Nov 13 1900 Get (In years FUNDER Last burthday) Months	Doys Hours Min
10a USLA	L OCCUPATION (Give k nd of work done and two kind of Business OR INDUSTRY CEM	11 B RTHPLACE (State or fazeign country), 12 (T ZEN OF WHAT
	ER'S NAME	14 MOINER'S MAIDEN NAME N. 1	XSH_
10 TAIL	VIRGII DAVIS	SARA MARGARet C	IARK
15 WAS (Yes, no c	DECEASED EVER IN LS ARMED FORCES? 16 SOCIAL SECURITY NO 17 princhrown) (1 yes g ve wor or dotes of service) 17-36-0827	RS DAVIS (WIR) WIRDLE Address	lle Md.
18.	CAUSE OF DEATH (Enter on y one couse per line for (o), (b), ond (c))	PARCE FLENA ACUE	INTERVAL BETWEEN ONSTI AND DEATH
1 5	MMEDIATE CAUSE (6) DUE TO	oney control of	130.000
	itions, if any, which gove to immediate couse (a).	<u> </u>	1346981
	ng the underlying couse (c)		
PART	I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERM NA. D SEASE CONDITION G YEN IN PART I(0)	19 WAS A TOPSY PERFORMED? YES NO
PRIM	EXTERNA. (A.JSE WAS LARY ☐ or CONTRIBUTING ☐ LARY ☐ or CONTRIBUTING ☐	(Enter nature of incry in Port or Port I of Item 18.)	
MEDICAL		CE OF INJURY (Home, form 20f (City or town) (Co fory, street, office bldg., etc)	ounty) (Stote)
2	I I certify that taak charge of the remains described above, he	eld an Autopsy 🔲 , Inspection 📈 Inquiry 🔲 ,	and in my apinian
d	eath resulted fram. Natural causes 🔀, Accident 🔲, Suic	ide, Homicide, Undetermined manner	
ACTU	JAI DOWNSON .	CH EF MED CAL EXAMINER M D ASS STANT MED CA. EXAMINER	22. DATE SIGNED
	MINER'S FJ. TOWNSEND JE	DEPUTEMENT CAL EXAM NER Adules (SIGNAT)	20471
230 8 Jk		CREMATORY (24 (0: MON (CHY of Town)	(County) (State)
24 Fuel	ADDRESS ADDRESS	250 REC D BY REGISTRAR D REGISTRAR'S	SIGNATURE
17%	Ur / Thales Selbery to de	1 99 JANISUL 25 1967 John	les Judges

VR A15ME (5)

5 may be retained for your files.

Health prior to burial, cremation, or remayal, and in any event within 72 hours ofter death.

the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

pending

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 haurs ofter death. If J

necessory, please execute the certificate writing the word

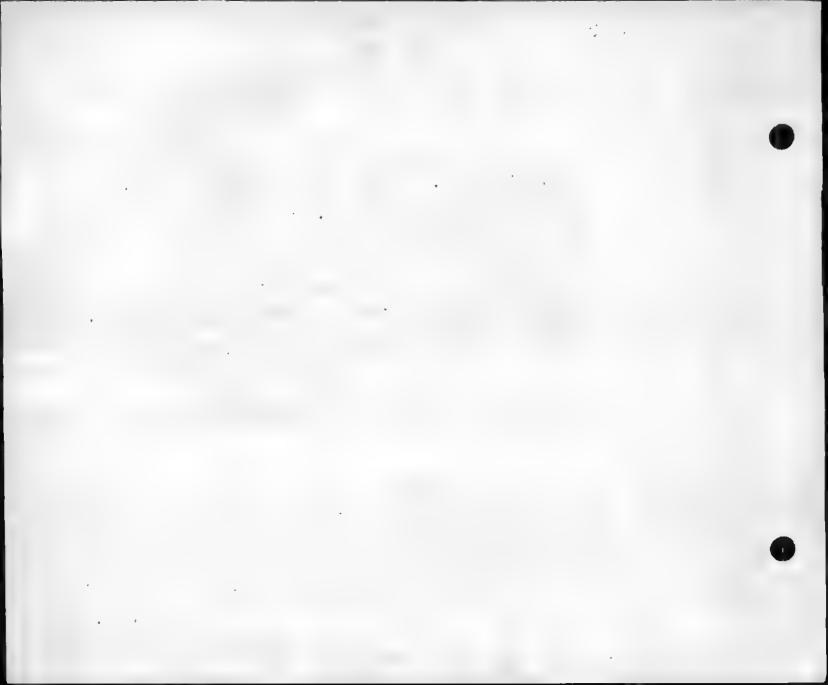


death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any every, within,72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Page 4 may be retained by the hospital or attending physician.

> VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1.	PLACE OF DEATH	Worcest				2. USUAL RESIDE	ENGE (Where		f institution:	Residence b	refore admission)
1		NOT GE BU	61.	MARY	LAND		rylar		60 H	este	r
	5. CITY OR TOW	N (If outside corpora	te Ilmits,	c. LENGTH OF STAT	Y IN 1b	c. CITY OR TOWN	(If outside	corporate limits	, write RURA	L and give	nearest town)
1	lishor	and give nearest too	V(1)	38 Y	ma	. 1	shopy	177.0			
		PITAL OR INSTITUTION		The second second	;	d. STREET ADDRES		<u> </u>		0.	IS RESIDENCE
		XX	(9,10 01,001				RFD		VE	ON A FARM?
2	NAME OF		leet.	Missis		Loca	LA DA		lonth	Day	Year
3.	DECEASED	Kather	irst 4 m a	Middle	-	Last	4. DA	711	_	Day	
	(Type or print)				Day	DATE OF BIRTH	DE	LI LI L		1967	19 UNDER 24 HRS.
		6. COLOR OR RACE	7. MARRIED	NEVER MARRIE	" A	DATE OF BIRTH		last birthd	ay) Months	Days	Hours Min.
	Female	White	WIDOWED.	DIVORCE		ec. 14,	1870	96 yr	s.		
10.	a. USUAL OCCUPAT ring most of work	ION (Give kind of working life, even if retire	done 10b. Ki	ND OF BUSINESS OF	R	11. BIRTHPLACE	(County & St	ate, or foreign co	untry) 12.	CITIZEN OF	F WHAT
-	Nurse			urse		Maryla	ทส			USA	
13	. FATHER'S NAM	E				14. MOTHER'S M					
		Unkn	own			Elizab	eth 0	8.V			
		VER IN U.S. ARMED F	ORCES? 16.	SOCIAL SECURITY NO	0. 17.	INFORMANT	COLL D		dress		
1,1	es, no, or unkown)	(If yes give war or dates	er service)	ハーデクーガタル	71-1	ora McCa	he ta	ala a ma d	77 - 7		
	18. CAUSE OF	DEATH [Enter only or	e cause per li	ne for (a), (b), and (OI a ILVE	UE BI	BUOON			VAL BETWEEN
		ATH WAS CAUSED BY	6	Denne	1/2					ONSE	T AND DEATH
	,	IMMEDIATE CAUSE		Coord	5	, ,	10	7			
	Conditions, If	DUE	1 / 11	001801	un	Hen	75	ande	100	10	MAC
	gave rise to	Immediate /	(b) C	or gene		- V - CC - C		cere	C C		10-
	cause (a), st	annik mol	TO								
E	underlying caus	G IAST.	(C)	TING TO DEATH DUT	MATRELA	TED TO THE TED MINA	II DISEASE O	ONDITION CIVE	M IM DART 1/s) 119.	WAS AUTOPSY
, ≗	PARTIL OTHERS	IGNIFICANI CONDITI	ON2 CONTRIBO	TING TO DEATH BUT	NUTKELA	IED IO INC LERMINA	AL DISEASE G	ONDITION GIVE	H IN PAGE 14	, I	PERFORMED?
E SE										YES	М0 [
CERTIFICATION	OR CONTRIBUTI (IF EITHER, NOT	WAS UNDERLYING T NG T CAUSE OF DEA TIFY MEDICAL EXAMI	TH 20b. D	ESCRIBE HOW INJU	IRY OGGU	RRED. (Enter nature	of injury ir	Part I or Part	II of Item 1	.ŭ.)	
		NJURY Month, Day,		JURY OCCURRED	2De. PLA	CE OF INJURY (Home	, farm, 201	. (City or tow	n) (C	ounty)	(State)
EDICAL	Hour a.n	٦.		Not While at work	factor	ry, street, office bldg	., etc.)				
Ξ	р.п				. <	1000	10//	1: /		/ 1	. 40 2 3 1 1
		y that (1) (this hos	pital) attende	7/ 4/3		THE !		to Jeres	7 , 194		t (I) (we) last
	saw the dec	eased alive on	VILLY	196	and that	death occurred a	L / /- M,	trom the cav	ses and on	DATE SIG	stated above.
1	228. STGNAHO	1 /19	0/4	11/1/		ATTENDING NO	MED.	STAFF	7	1////	
	220. PHYSICIA	MIS NICE	The	mg /	M.D	. PHYS. 22d. ADDRESS.	DIRECTOR	PHYS.		1 (40)	1.1
	NAME (Ty	BUK T	=, 6	anto	34	1 Junes	Bay	5%.	150	-/1	4140
23.	REMOVAL (Spe		THEREOF		EMETERY	OR CREMATORY	23d.	LOCATION (CI		ounty)	(State)
24	I. FUNERAL BINE	CTOR	0	OCC FE	TTO	25a.	REC'D BY RI	EGISTRAR 25b	REGISTRA		
1	1/tim	The	ul X	allega	ello	Sel. DATE	L10	1967	Elian	es Ju	tge
=		1-1-1-12	1-1-9								



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE		10370	MEDI	CAL EXAMINER'S	CERTIFICATE O	F DEATH	-	1	*
EALTH DEPT.		PLACE OF DEATH COUNTY Worcester		MARYJAND	2 USUAL RESIDENCE (V	Where deceased lived, if yland	b CDUNTY	esidence before Harfor	d dmission)
Po Po		CITY OR TOWN (foutside corporate limits,		C LENGTH OF STAY IN 16	c CIY DR TOWN (I au	tside corparate limits, v	vrite RURAL ar	nd give neares	town)
T, Z, and 3 to my leavy in many delay in many pogramment of the many page of the many many many many many many many many	I	Rural-Pocomoke Ci	ty	3 days	Jop	pa 210	085		
E 2 00		HAME OF HOSPITAL OR INSTITUTION (I not	in haspital giv		d STREET ADDRESS	**************************************			e .S RESTDENCE ON A FARM?
- L Se - L	I	Pocomoke River			114	Doncast	er Roa	ad	YES [] NO
offer deoth Its 8 Give Mages I, olong with form with the State De		NAME OF First DECEASED Type or print) NETLVI		Midd e RUSSELL	DICKEY	4 DATE OF DEATH	Month July	10,	Year 19 67
Given Given	S		7 MARRIED	NEVER MARRIED	8 DATE OF BRTH	9 AGE (In ost but	years IFU	NDER 1 YEAR	F UNDER 24 HR
ors of 18 of		Male White	WIDOWED	DIVORCED	March 22,	1918 49	yrs		
w thin 24 hours n pencil in Item xaminer s Offiliss File pages lond 2 Phours offer deat	10a duri	JSUAL OCCLPATION (Give kind of work done ng most of working life, even if retired) Machinist	OP KIM	of Business OR as & Electric		ryland		COLNTRY?	
hours of	13	FATHERS NAME Melvin R.			14. MOTHER'S MAIDEN I	NAME Auri	nthia 🌡	dkins	
executed within 24 hours after IIII a in pencil in Item 18 Gi Medicol IIIxaminers Offilms olong to permit. File pages Lond 2 with within 72 hours ofter death.	15 (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? s, no. or Juknown) (If yes on wear of dates of	16 SC 215	17 -10-3260 Mr	nformant s. Stant Glady	ys Dickey	Address	(San	ne)
s cerrificate should be executed within 24 hours of wurting the word 'perling in pencil in Item 18 forwarded to the Chief Medical Examiners Office of used as a burial-transit permit. File pages land 2 within 72 hours ofter death.		18 CAUSE OF DEATH (Enter only one cause PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (or DUE TO Conditions, if ony, which gove isse to immediate cause (a), stating the underlying cause last	A A	a), (b), and (c))		RUZU NI	NG_	ON:	ERVAL BETWEEN SET AND DEATH
writ orwar used ovol,	岩	PART II OTHER SIGN F CANT CONDIT ONS COL		DEATH BUT NOT RELATED TO	THE TERM NAL DISEASE COM	DITION GIVEN IN PART	1(0)	19	WA, A. TOPSY PERFURMED?
ofe, of for	B	NON	_					Y	S NO X
INER: This certificate should be files. 3 should be fron, or rem	L CERTIFICATION	200 EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTING □ CAUSE OF DEATH	20b DESC	RIBE HOW INJURY OCCURRED	(Enter nature of injury in				
EXAMINER: This certificate, writing 4 should be forwaryour files. Page 3 should be used cremation, or removal,	MED.CAL	20c TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19	20d N. While at work	Not While if fact	CE Of IN.LRY (Home farm ary, street, office bldg , etc.)	20f (City or	rwot	(Caunty)	(State)
		21. I certify that I toak charge	af the rem	ains described abave, ne	ld an Autopsy 🔲,	Inspection 🔀	Inq .iry	X , and	in my apinio
DEFUTY MEDICAL Ecessary, please exe in funeral director I may be retained for FUNERAL DIRECTOR eoith prior to bunal		ACTUAL SIGNATURE EXAMINER'S NAME Type) Robert (C. LaM	Accident X Such	CHIEF MEDICAL M D ASSISTANT MED DEPUTY MED (A Address (Street	EXAMINER	now H aryla	ill, ind 7	22. DATE SIGNEI
necessar the fune 5 may to 10 fune Health	230	BUR AL (REMAT ON, 23b DATE THER REMOVAL (Specify) 7/17/6		23c NAME OF CEMETERY OR Beltimore Nat	ional Cemete		ty of Tay		(State)
VR A15ME (5)		EUNERAL DIRECTOR CONTROL FUNCTION FUNCTION FOR THE CONTROL FOR		More, Md. 212	14 PATE UL	BY REGISTRAR 1 4 1987	250 pelia	AR S SEGNATUR	edge.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212010 0 1

	10321	MEDI	CAL EXAMINER'	S CERTIFICATE OF	DEATH	J. 0 3 W. E
	PLACE OF DEATH		_		are deceased lived, funstitution Re	sidence before admission
	· COUNTY WORC	ester	MARYLAND	O STATE MO	b CO-NTY	hington
	b CITY OR TOWN (f outside co		C LENGTH OF STAY IN 16	c CITY OR TOWN (if outs	de corparate limits, write RURAL an	d give nearest town)
	WITHE KOKAL BUTCHEN	21 CH4	DO A4S	HAGE	stown	
	d NAME OF HOSPITAL OR INST	TUTION (finat in haspital, gi	ve street oddress)	d STREET ADDRESS	(01 /	9 IS RESIDENCE ON A FARM?
	Stre			1270 /2/	eram DIVA	YES NO
	NAME OF DECEASED (Type or print)	nos Ric	hasa	DWYER	4 DATE Month OF DEATH	7 19 6 7
_	SEX 6 COLOR	QR RACE 7 MARRIED	NEVER MARRIED	8 DATE OF BIRTH	9 AGE (In years IF U	NDER 1 YEAR IF UNDER 24 HRS
(Mu	WIDOWED	DIVORCED	Oct 9,191	Jost birthdoy) Mon	ths Days Hours Min
10a	USUAL OCCUPAT ON (Give kind	of work done 10b K h	D OF BUSINESS OR	11_BIRTHPLACE (State or		COUNTRY?
uci	Sostat ark ng lite, even it	emedy	Pedicine	Kenono	LENN	CSH
13	FATHER S NAME			14 MOTHER'S MAIDEN NA	WE OF 17	110
	r R F	+411	wwyer	(4)	AIRY MOU	3611
15 (Ye	was DECEASED EVER IN 5 ARI es, na grunknawn) (if yes give	MED FOR (ES? 16 S war ar dates of service) 22 (0CIAL SECURITY NO 11	W. JAMES	Dwyer (WIFE	HAGERSTOWN.
	IB CAUSE OF DEATH (Enter	any one cause per line far		0.1	1 -	INTERVAL BETWEEN ONSET AND GEATH
	PART DEATH WAS CAU MME	DIATE CAUSE (a)	-40 RONAG	Ry C/CCI	USION HCU	TO THE DO
	-/-	DUE TO	61100	1.46 pm	ovary Schero	ce williams
	Candit ans, if any, which gov rise to immediate couse (o		L2C. NI	CO ITY COM	Juney Science	AZ ON K WOWN
	stating the underlying cous					
	last	(c)				
CERTIFICATION	PART II OTHER SIGNIFICANT (ONDITIONS CONTRIBUTING TO	DEATH BUT NOT RELATED T	O THE TERM WAL DISEASE COND	T ON G VEN IN PART I(a)	19 WAS AUTOPSY PERFORMED? YES NO
][E	200 EXTERNAL CAUSE WAS		CRIBE HOW INJURY OCCURRI	D (Enter nature of injury in Pa	rt (ar Part (af item TB)	
	PRIMARY C or CONTRIBUTING CAUSE OF DEATH					
MEDICAL	20c TIME OF INJURY Manth, Haur a.m.	Day, Year 20d IN While at work	Not While	PLACE OF INJURY (Hame, farm factory, street, affice bidg., etc.)	20t (City ar town)	(Eaunty) (State)
		ook charge of the rem		held on Autonsy	Inspection Inquiry	and in my ap n an
	death resulted fram	Notural causes		uicide . Hom.cide [Undetermined manne	
	~	1		CHIEF MEDICAL E)		
	ACTUAL SIGNATURE	Murisa		M D ASSISTANT MED C	A. EXAMINER	22. DATE SIGNED
	EXAMINER'S	Ly	(1)-	DEPLITY MEDICAL		744,7,67
	NAME (Type)) OWN-	ENGLAR	Eddress Dear	My (Wash prop), Md	(/
230	BURIAL, (REMATION, 2 REMOVAL (Specify)	3b DATE THEREOF	23c NAME OF CEMETERY		23d LOCATION (City or Town)	(County) (State)
	"CULTATIVE	7-10-67	Kest Have	n Cemetery	Haganetawa	Ma

ADDRESS

Minnich Funeral Home, Hagerstown, Md.

D BY REGISTRAR L 1 1 1967

delay the State Departm in pencul in Item 18. Give Pages 1, Office alang with form This certificate shauld be executed within 24 Mours after dmath If necessary, please execute the certificate, writing the word "pending" in pencul in the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's AL EXAMINER: 5 may be retained far yaur TO MEPUTY

FOR STATE HEALTH DEPT.

F-22 hours after death

pages land 2 w

a berial-fransit permit. File

". Health or its designated agent, prior to burial, cremation, ar removal, and in any event within

VR A15ME 67.

24 FUNERAL DIRECTOR

TO FUNERAL DIRECTOR: Page 3 shauld be used as



10322 FOR STATE HEALTH DEPT. 1. BLACE OF BEATH 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a bunal-transit permit. File pages I and 2 with the State Department of FUNERAL DIRECTOR. O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 pour after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil invitery 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with farm. PM3. Page

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

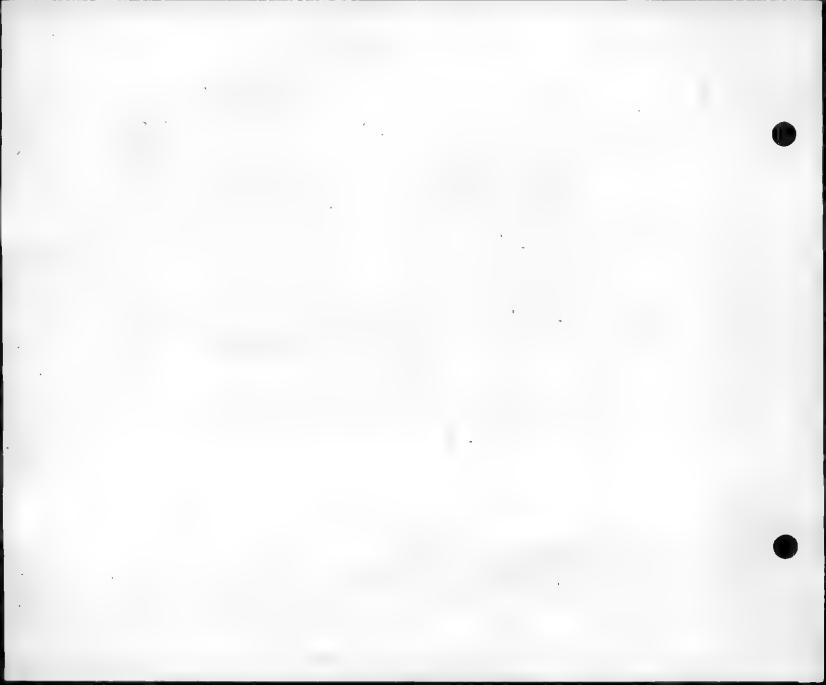
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Ш		DUTY /		Z OSDAŁ PISIDENCE (Whele detended lived it institut	ion, kez delike belote odli izzioni
H	0 (00	UNITY GIORCES FER	MARYLAND	" TENNSULVANIE "	WestmarelANd
	p (II)	Y OR TOWN (If outside corporate limits, see RURAL and give necest town)	c LENGTH OF STAY IN 16	c CITY OR TOWN (+ outside carporate -m ts write RU	
		cean Cuty	OdAys	New Kensings	DN.
	d NAJ	ME OF HUSPITAL OR INSTITUTION (Ill not in	bospital, give street address)	d. STREET ADDRESS	B IS RESIDENCE ON A FARM?
		du Ality	Motel	1016 PARK VIEW	KIVC YES NOTE
	3 NAME DECEA	ISED I ARAIA	ARTHUR F	Apicas 4. DATE OF OF	th Doy Year
	S SEX	or print) 6 (OLOR OR BACE 7	MARRIED NEVER MARRIED	B DATE OF B,RTH 9 AGE (n veors	FUNDER I YEAR IF UNDER 24 HRS
			WIDOWED DIVORCED	APRILIS, 1918 (pst businday) yrs	Months Doys Hours Min
	10a USUA	A. OCCLPATION (G ve kind of work done	106 KIND OF BUSINESS OR	BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT
	-	Morking Reven Lettred) V+	Food	PRACKENRIAGE FA	COUNTRYS
	13 FATH	IER'S NAMED	101/05	THE MOTHER MAIDEN NAME	1 00 4 01
	1c war	Dreft (CD DV D IV)	HKNHS	Cose PRIEC	1111140
	(Yes, no,	DECEASED EVER IN U.S. ARMED FORCES? or unknown) (If yes give wor or dates of se	ervicel - A	INFORMARY Addr	1.1 -
	10	CANCE OF DEATH (Subscious and Concession	167-07-51730	MAN HAM KIES	INTERVAL BETWEEN
	I B	CAUSE OF DEATH (Enter only one couse part DEATH WAS CAUSED BY IMMED ATE CAUSE (a)	1 00001	ARY Occuran Ac	ote posti and death
1		DUE TO	A C = -		
ı		ditions if any, which gave) (b)	H>CO	1)	ONKNOWN.
ı	stote	ng the underlying couse DUE TO	•		
1	last) (c)			
	8 PART	TIL OTHER S GNIFICANT CONDITIONS CONT	1 40	THE TERM NAL DISEASE CONDIT ON G VEN IN PART 1(0)	19 WAS ALTOPSY PERFORMED?
1	EA	/ V	ONE		AR WO
	PRIA	EXTERNAL CAUSE WAS WARY □ or CONTRIBUTING □ SE OF BEATH	20b DESCRIBE HOW INJURY OCCURRED	(Enter nature of injury in Port I or Port II of item 18)	,
	WEDICAL 20c	TIME OF INJURY Month, Day, Year	20d INJURY OCCURRED 20e PL	ACE OF INJURY (Home, form 20f (City or town)	(County) (Stote)
	ME	Hour o m.	While Not While of work	ctory, street, office bldg etc.)	
1	2	I certify that I took charge o	f the remains described above, h	eld on Autopsy , Inspection Inqu	uiry , and in my apınian
ľ			the second secon	cide, Homicide, Undetermined m	
1	ACTI	UAL OF	10	CHIEF MEDICAL EXAMINER	22. DATE SIGNED
		VATURE	Mann.	M D ASSISTANT MEDICAL EXAMINER	1.1.
	E E Y A			PEPUL MIDICAL CAMBILLER	
		MINER'S AE (Type)	WIN SPNd. JK	Milestistet Guordo or AAM	1000
	NAN 29c BUR	ME (Type) 23b DATE THERES	WNSER & JK		way
	NAN 29c BUR	AE (Type)		Amin's Section and the second	BURBELL PI
	29c BUR BREM	ME (Type) 23b DATE THERES		CRIMATORY (ADISHA 1-0WER	BURRELL PI

VR A 15ME (5) 6M 1/67

TO DEPUTY MEDICAL EXAMINER:



TO HOSPITAL ILTENDING PHYSICIAN: The law requires that the death certificate be executed w 24 hours after death. Page 4 refained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. VR A15 (4)

	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH
	1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL OR INSTITUTION (F not in hospital, give stread address) 423 Coving ton 54. Widdle Last 4. DATE Month Day Year ON A FARM? YES NO NO The property of the party o
	(Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years V UNDER 1 YEAR F UNDER 24 HRS. Inst bushday) Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working [Je, eyen if refired) 17. CITIZEN OF WHAT COUNTRY.
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 17. INFORMANT Address Address Address
	18. CRUSE OF DEATH [Enter only one cause par line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO DUE TO
	Conditions, if any, which gave rise to immediate cause (e), stating the underlying couse last. (b) General 31 General 32 General
	PERFORMED? YES NO 206. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURED. [Enter natura of injury in Part I or Part I of Itam 18.] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20a. PLACE OF INJURY (Home, farm, 20f. [City or town] (County) (Shata) Whila Not While at work 19 19 19 19 19 19 19 1
	228. S.GNATURE 228. S.GNATURE 228. S.GNATURE 228. S.GNATURE 228. S.GNATURE 228. DATE SIGNET 7.28-67 220. DATE SIGNET 220. ADDRESS NAME (Type) DAVID RAFAT 221. ADDRESS STATE PHYS. D ATTENDING MED. STAFF PHYS. D 7.28-67 221. ADDRESS STATE PHYS. D ATTENDING MED. STAFF SIGNET 7.28-67 221. ADDRESS STATE PHYS. D ATTENDING MED. STAFF PHYS. D ATTENDING MED. S ATTENDI
	236 BURIAL, CREMATION 236. DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, Town or county) (State) PROVAL, (Spacify) 7-31-67 COISPYING CEM. TWOLETICE MODELS SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS AND COMMENT AND COUNTY SIGNATURE ADDRESS
>	anu Jack y Kulnurch, Va, I DATE HOU

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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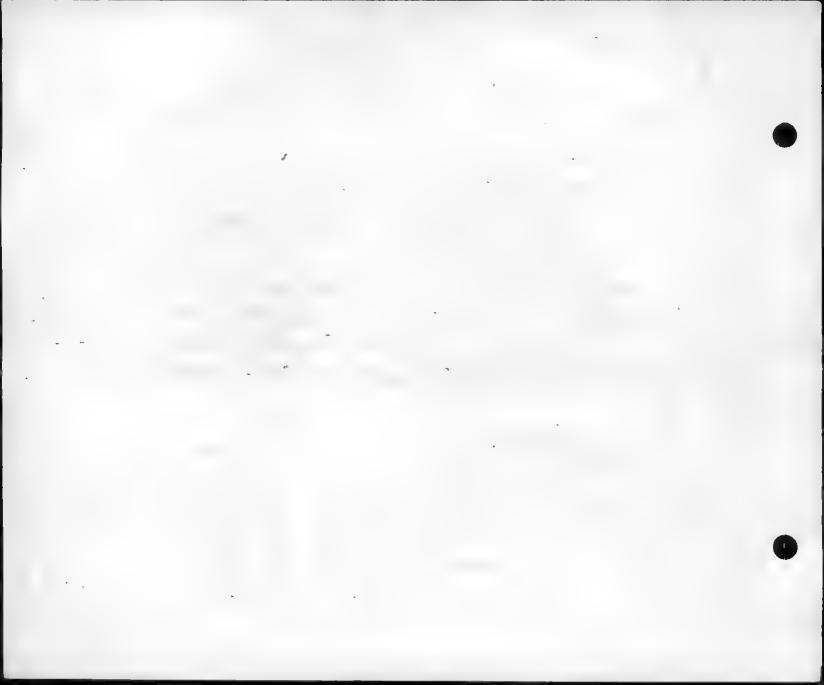
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

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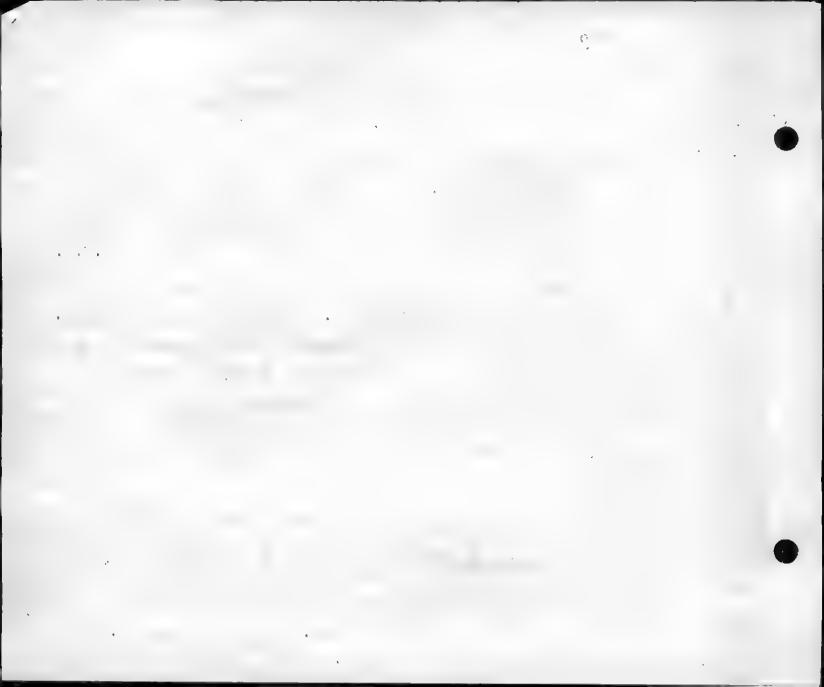
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

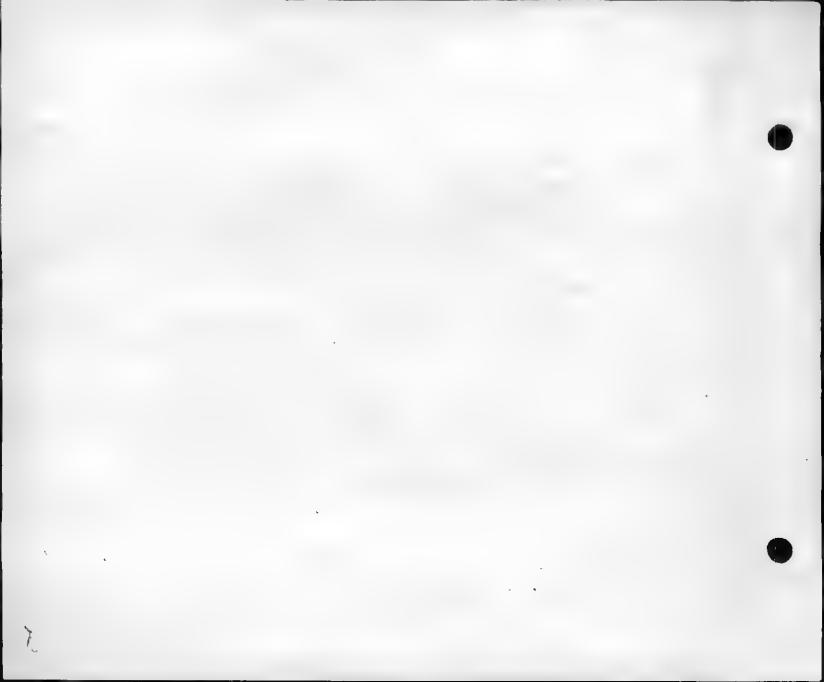
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₽8 ₹ 6 8	1		NAME (Type) David R	afat MD	Snow H	iill, Maryland			
Page 4 r O FUNER director, should b	1	23a	BURIAL, CREMATION, 236 DATE THE	REOF 23c NAME OF CEMETERY OR	CREMATORY	23d LOCATION (City or Town)	(County) (State)		
Page o FUN direct should			REMOVAL (Specify) Buriol 7/15/	1967 Methodist	Ó am	Stockton Ma	. , , ,		
F - F		24	FINERA DIRECTOR	ADDRESS ADDRESS	250 BEGD	RY REGISTRAD - 1 25h PERSUPAR	CIGNATURE		

Snow Hill, Md.

VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH VISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7 9 hours after death. PLACE DE DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Worchester orchester MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) physician and completely filled in by a please remove carbon papers. Page val, and in any event, within 72 hours Bishopville Bishopville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? K No PHYSICIAN: The law requires that the death certificate be executed within 3. NAME OF First Middle Last Month 4. Day Year DECEASED OF DEATH 67 (Type or print) Clarence Alfred Melson 19 5. SEX 6. COLOR OR RACE I DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED TA NEVER MARRIED last birthday) Months | Days Hours WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Poultryman Poultry USA Maryland removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME been signed by the attending pl the burial-transit permit. Then to burial, cremation, or remova Elizabeth Melson fred Melson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) Melson Bishopville e World War Grace Yes 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN DNSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating underlying cause last. When this certificate has be detached for use as State Dept. of Health || Itilia CERTIFICATION PART II JOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2) WAS AUTOPSY PERFORMED? YES -NO 20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part | or Part | of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, I (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. After d be d While Not While ATTENDING p.m. at work at work director, page 3 should be should be filed with the S retained 21. I certify that (i) (this hospital) attended the deceased from to. 19 00 Apr. saw-the deceased alive on and that death occurred at. M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED Aug. ATTENDING DIRECTOR M.D. PHYS. PHYS. 4 may 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS Selbyville, Delaware Jack Lewis. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, 23h. (State) REMOVAL (Specify) Odd Fellows Cemetery Bishopville, Maryland Burial FUNERAL DIRECTOR REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) I PLACE OF DEATH a STATE b. COUNTY a COUNTY the certificate, writing the word "pending" in pencl in Item 18. Give Pages 1, 2, and 3 to 4 should be forworded to the Chief Medical Examiner's Office along with form PM3. Page Department of MARYLAND delay C JENGTH OF STAY IN b puo ON A FARM? d STREET ADDRESS give street address NO in pencil in Item 18. Give Pages DATE DECEASED DEATH (Type or print) S SEX 6 COLOR OR PACE i buriol-transit permit. File pages land 2 w in any event with n 72 nours ofter death W DOWED 12 CITIZEN OF WHAT 10a USUA_QCC_PATION (Give kind af wark dane 10b KIND OF BUS NESS OR during prost of working it INDUSTRY 13. EATHER'S NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES? 18 CAUSE OF DEATH (Enter only one cause per line for (a) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate cause (a), **DUE TO** stating the underlying cause o. and 00 last. 19 WAS ALTOPSY may be retoined for your files. FUNERAL DIRECTOR: Page 3 should be used ONS LOWER BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) prior to bunal, cremation, or removal, 20a EXTERMAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) PR MARY S or CONTR BUTING CAUSE OF DEATH MEDICAL EXAMINER: 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (County) (State) TIME OF INJURY Month, Day, Year straet, office/bldg , etc.) Not While 21. I certify that I took charge of the remains described above, held on Autopsy ond in my op n on Undetermined monner the funeral director deoth resulted from Noturo couses be retoined ACTUAL 22 DATE SIGNED SIGNATURE **EXAMINER'S** £ NAME Type Hea t CREMATION 0 NERAL D RECTOR 24 VR A15ME (5)



MARYLAND STATE DEPARTMENT OF THESE TO THE DESCRIPTION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201-

10331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH			(Where deceased lived, it institution: R	esidence before admission)				
o COUNTY	MARYLAND	o. STATE	b. COUNTY	/-				
b CITY OR TOWN (.f. outs de corporate limits.	C LENGTH OF STAY N ID	CITY OF TOWN		rcesier				
write RURAL and give nearest town)	C LENGTH OF STATE A ID	C CIT OK TOWN ON C	outs de corporate limits, write RURAL or	a give neorest town)				
Snow Hill		Nurs/	Snow Hill					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital	l, give street oddress)	d STREET ADDRESS	•	e IS RESIDENCE ON A FARM? YES NO				
NAME OFFirst	Middle	Lost	4. DATE Month	Doy Year				
OFCEASED (Type or print)	2	Northann	DEATH dela	27 1967				
SEX 6 COLOR OR RACE 7 MARRIED	NEVER MARRIED	8 DATE OF BIRTH	9 AGE (n years F L	NDER I YEAR IF UNDER 24 HRS				
Garage 1116 to WIDOWE		T- 10 10	lost birthdoy) Mor	iths Doys Hours Min				
Chiale While		72n / 196	4 63 Yrs	TO CITIZEN OF MULT				
0o. USUAL OCCUPAT ON (Give kind of work done Ob uring most of working life, even if retired)	KIND OF BUSINESS OR	11 BIRTHPLACE (Stot	e or foreign country)	12 CHIZEN OF WHAT COUNTRY?				
Housewife a	un tome	West	Ircinia	11.5. A				
3. FATHER S NAME		14 MOTHER'S MAIDEN	NAME					
Alarandon Burns		Alia	Hatfield					
IS WAS DECEASED EVER IN IIS ARMED FORCES?	6 SOCIA, SECURITY NO. 17	INFORMANT	Address					
(Yes, no, or unknown) [(If yes give wor or dates of service)]	o social steparitino	mioninini	-41					
No	None_S.	OTIS NOT	Tham Snow HI	Il Mil.				
18 CAUSE OF DEATH (Enter only one cause per me f	or (a), (b) and (c).)			NTERVAL BETWEEN				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0)	1 ARD IAC	ARP.DS	T	ONSET AND DEATH				
DUE TO				77,77				
Conditions, If any, which gove) (b) ACUTE COROWARY OCCLUSION MINUTE.								
rise to mmed ate calculate	C 0 12 CUI	The Most	DEC EUSTON	7011100				
stoting the underlying couse DUE TO								
last. (c)								
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	DNO TION GIVEN IN PART I(o)	19 WAS AUTOPSY PERFORMED?				
				YES NO				
200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH.	OESCRIBE HOW INJURY OCCURRED	(Enter not ire of in inv in	Port Lor Port Lafutem 18.)					
PRIMARY Or CONTRIBUTING		(**************************************						
CAUSE OF DEATH.								
20c TIME OF NJURY Manth, Doy, Year 20d Who		ICE OF INJURY (Home, for tory, street, office bidg , etc		(County) (State)				
pm 19 of w	ork O of work	iory, sireer, orrice blog , ere	'					
21. I certify that I tack charge of the re	emans described above hi	eld an Autopsy	Inspection 🔀 , Inquiry 🕽	ond in my opinion				
death resulted from: Natural causes								
deoil lesoled from: Natolal (doses	Act defil [], 301							
ACTUAL / 1 - A /	- Ma	CHIEF MEDICA		22. DATE SIGNED				
SIGNATURE / CONTINUE TO	7 //01	IN. D	O.CA. EXAMINER L	22. DATE STORED				
EXAMINER			CAL EXAM NER	7/281/-				
NAME (Type) Robert C. La Mar,	M. D., 104 Bay	Streetingss (Sm	owy. Hidd golded.	1/20/4/				
230 BUR AL CREMATION, 236 DATE THEREOF	23c NAME OF CEMETERY OR	CREMATORY	23d LOCATION (City or Town)	(County) (State)				
Buris dulu 29 196	1 Whateost	Moth	Sugar Hill	Med.				
24 FUNERAL DIRECTOR	ADDRESS	250 REG	D BY REG STRARADO - PSb REGISTRA	AR S SIGNATURE.				
2 11/	114	1 40 - 3	OF 2 T 1901 1	carter Judge				

TATE DEPT. P.M.3. Page "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to oth the State Department of eny delay's the funeral director. Page 4 should be forwarded to the Ch ef Medical Examiner's Office along with farm This certif mate shamld be exacuted within 21 haurs after death 1f TO FUNERAL DIRECTOR: Page 3 should be used as a bur'al-transit permit. File pages land 2 necessary, please execute the cert ficate, writing the ward AL EXAMILER: 5 may be retained for your files. TO DEPUTY MED

haurs after death

Health ar its designated agent, priar to burial, crematian, ar removal and in any event

VR A15ME 6M 1/66



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24 hours after death.

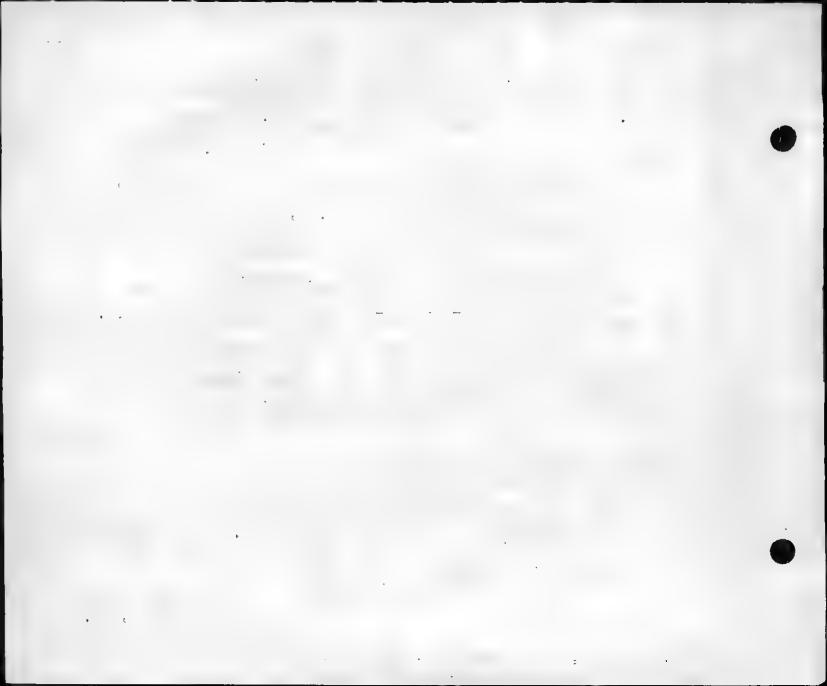
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funds director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages It and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, when 72 hours after beauti

THE MISHTAL OR ETTERMENT THE NAME THE NAME OF THE TRANSPORT OF THE PROPERTY OF

VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 10332 CERTIFICATE OF DEATH 10001

_ 4000	
1, PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
Worcester Maryland	a. STATE Maryland b. COUNTY Wordester
b. CITY OR TDWN (if outside corporate 1 mits. C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
write RURAL and give nearest town) St. Martins Life	St. Martins
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS 6. IS RESIDENCE
,	ON A FARM?
O MANE DE	Berlin, Md. RFD YES X NO
3. NAME DF First Middle DECEASED	Last 4. DATE Month Day Year
(Type or print) Amanda Adkins	Scott DEATH July 28, 1967 19
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8	last birthday) Months Days Hours Min.
Female White WIDOWED DIVORCED O	ct. 1, 1884 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Housewife Own Home	Maryland USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nosh Adkins	Rittie Baker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT Address
(Yes, no, or unkown) (If yes give war or dates of service)	Coone Advisor Newline No. DED
18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	George Adkins Berlin, Ma. RED
PART I. DEATH WAS CAUSED BY:	ONSET AND DEATH
IMMEDIATE CAUSE (a)	1 your acces
DUE TO John T	
Conditions, if any, which gave rise to immediate (b)	onlean
cause (a), stating the DUE TO	along and
underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELAT	TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY PERFORMED?
log /	YES NO
PART II. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART III. OTHER SIGNIFICANT CONDITIONS DONTRIBUTIONS DONTRIBUT	RRED. (Enter nature of injury in Part 1 or Part II of Item 18.)
	CE OF INJURY (Home, farm, 2Df. (City or town) (County) (State)
Hour a.m. While Not While factor	y, street, office bldg., etc.)
	1-1-7-7
21. I certify that (I) (this hospital) attended the deceased from	19 to 19 that (I) (we) last
	death occurred at A. M, from the causes and on the date stated above.
22a. SIGNATURE	ATTENDING CO. MED. STAFF CO.
M.D.	PHYS. DIRECTOR PHYS.
22c. PHYSICIAN'S OFIF FOR A E. Schotly	22d. ABBRESS 20 Berly Mdg
23a. BURIAL, CREMATION, 23b. BATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 230 LOCATION (City, town or county) (State)
24. FUNER DIRECTOR	25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE 3 1 1967 Charles yuage
The production of the	DATE /



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10333

FRTIFICATE OF DEATH

10322

(10		CERTIFICATE OF DEATH	2.0000
E 12/8/11		PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Reside	nce before admission)
funeral and er deat		O COUNTY W COLLO MARYLAND O STATE W COLL PORT 6 COUNTY 14 9	avo.To
e fues les l	-	b CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 1b C CITY OR TOWN (If outside corporate limits, write RURAL and g	ve negrest town)
by the fr Pages naurs afte		RURAL and give necrest (gwn)	***************************************
n by s. Pa	_	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS	I B IS RESIDENCE
ed ir		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 209 Lindon 1000	ON A FARM? YES NO
within ban po	3.	NAME OF First Middle lost 4 DATE Month	Day Year
a wirr ertely arbar nt, wi		DECEASED (Type or point) JOSEPH SIMPKINS DEATH DILLY	7 1967
red veni		SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 ARE AN YEORS A UNDER	1 YEAR IF UNDER 24 HRS
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certificate bi g physician g lihen please maval, and	10	Relied Farm heart The	13/7/
phys en p aval,	13	FATHER'S NAME	
cerr ing p	L	untinous untinous	
		WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT 2 Address 2	C 9 Rindona
death aftendin permit. an, or re	100	qua way foremal	ce very
that the dan. by the attributions it per	-	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN
hat the death n. y the attendin ansit permit. remation, or re		PART I DEATH WAS CALSED BY IMMEDIATE CAUSE (0) ACUTE CORCHARY THEARCTION	ONSET AND DEATH
s that cian. d by th transit , cremo		OUE TO	
hysici igned urial-		Conditions, if any, which gave) (b) / UFTIC AORTIC INSUFFICIENCY	7-5V06
President of the second of the		lise to implediate coose (a),	137/13
en en en to		storing the underlying couse	
te law tendi as be as th priar		The state of the s	19 WAS AUTOPSY
he afte date of he	8	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	PERFORMED?
the state of	CERTIFICATION	GEN ART. SCIEROSIS.	YES NO
草で音音楽	RTE	200 ACCIDENT WAS UNDERLYING 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH	
spi spi	3	(IF EITHER, NOTIFY MEDICAL EXAMINER)	
is he de	MEDICAL		ounty) (State)
	ME.	Haur a.m. While Not While foctory, street, affice bldg, etc.)	
\$ \$ \$ \$ \$ \$		21. I certify that (1) (this haspital) attended the deceased fram 10/24, 19/4, ta 7/7, 19/19	that (I) (we) la
the Section of the se		saw the deceased alive an 19/11/19/19/19/19/19/19/19/19/19/19/19/1	
15 5 5 £		22o. SIGNATURE 22b. C	DATE SIGNED ,
# 3 # E = 5 # 5 # 5 # 5 # 5 # 5 # 5 # 5 # 5 # 5		Bergn MD PHYS DIRECTOR DIRECTO	17/17
y be 3 pe 3		22c, PHYSICIAN'S 22d ADORESS	
B A B		NAME (TYPE) NEVILLE A. BARCH POCOMOKE, MI).
of draw and a second	23	BUR AL, CREMATION, 236 DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d TOCATION (City or Town)	(County) (State)
Page 4 directo	F	SREMOVAL Specify 7-10-67 Mt. Olice Boot Com Vinges Un	some +M
5 0 VK	24	1. FUJERAL OIRECTOR ADDRESS , 1 250 REGISTRAR , 255 REGISTRAR'S	S GNATURE ()
VR A15 (4)		10 11 12 1967 / Steen Vanue JUL 12 1967	They know



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10333

TOR STATE	
HEALTH BENT.	1 PLACE OF DEATH 2 USUAL RESIDENCE (Whele deceosed led if inclination Residence before admission)
2 2 2 2	T. COUNTY JORGOSTER MARYLAND O. STATE MA HAVING ARUNDES
5 m 2	b CITY OR TOWN (if outside corporate impts, CLENGTH OF STAY N 1b CTTY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
de me	Will RURAL and give nearest lawel
P. ort	UCEAR CITY I alty GEEN PURNIE 02.2
Sep 1.2	d NAME OF HOSPITAL OR INSTITUTION (III you in hospital, a verticed oddress) d STREET ANDRESS e IS RESIDENCE
es 1, form form	Stow Away Motel HARKING LUT. CIRNWOOD AUG 409 YES NOW
Pages Pages vith far State	3 NAME OF First Middle Lost 14 DATE Manth Day Year
death Pag with	(Type or point) HCRBERT ANDREW STRAITZ OFFITH GULY 1/ 1967
after death If Gry deads. S. Grve Pages 1, 2, and 3 along with farm PM3 P with the State Department.	(Type or pnnt) DEATH 190 S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGC (In years FUNDER 1 YEAR IF JNDER 24 HRS
aft 8. Galo alo wit	lost bethdown Manths Days Hours Ma
	M DOWED DIVORCED 12-30-26 UD yrs.
hours Item 1 Office and 2 r death	10b. KIND OF BUS NESS OR 11 AIRTHPLACE (Stote or foreign countly) 12 CITIZEN OF WHAT COUNTRY?
24 s	during most of the thing to extra the transfer with the transfer w
The second second	13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME
with n pencil n Examiner File, page	FREJERICK G. STRAITZ MARTHAE SCHMIDT
0 = 5	IS WAS DECEASED DIFFE INTERSECTION OF THE SECOND SECURITY NO. 17 INFORMANT Address
execute nding" Medical permit w thin 7	(Yes, no. prunknown) (If yes one was or dates of service) 217-20-6235-MRS 9RORIZ MSTRAHZ WIFE
execute nding" Medica permit	LINE OF STATE OF STAT
e e e e e e e e e e e e e e e e e e e	PART I DEATH WAS CAUSED BY
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shauld be as word 'pe a the Chief burial-transit any event	Continue if any which are a first the COLD'
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o ± + .=	stoting the underlying couse \ DUE TO
fica indec	lost. (c)
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This certicate write of farwa be used removal,	PERFORMED? YES \ NO \
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MINE of the control o	20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Hour o.m. 19 While Not While foctory, street, office bldg , etc.) (City or town) (County) (State)
te day age	pm. 19 of work of work
Page Page 7, cr	21. I certify that I took charge of the remains described above, held an Autopsy , Inspection Inquiry , and in my apinion
se exector. I can be for for for formal burnal	deoth resulted from. Natural causes Accident , Suicide , Hamicide , Undetermined manner
	CHIEF MEDICAL EXAMINER
	ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
ary, plusary, plusary	DEDUCED AND CALL PRACTICE OF THE CALL PRACTICE OF T
DEPUTY ressary, e funera may be funeRAl safth pric	EXAMINER'S AND COUNSENDED AND COUNTY OF COUNTY
D S o EE S	230 BURIAL CREMATION 23b DATE THEREOF 23c NAME OF MITERY OR CREMATORY 23c OCATION 1 TOWN (County) (Stote)
5 = + 25 ±	Burial 14 July 67 Baltimore National Baltimore, Maryland
VR A15ME (5)	Kirkley Funeral Home, Glen Burnie, Md.
	DATE IN THE PROPERTY OF THE PR



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333	5		CERTIF	ICAT	E OF DEAT	TH		Reg. Dis	t. No.	1000
1. PLACE OF DEATH o. COUNTY. WOTO	ester		MARYLA	- 11	o. STATE		ed lived If institu	olion: Residenc	e before	admission)
b. CITY OR TOWN RURAL and give i	(If outside corporate lim	16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Pocc	moke City				Wenona				м	
d. NAME OF HOSP OR INSTITUTION	TAL (If not in hospital,	ive street oddre	rss)		d STREET ADDRESS				Te.	IS RESIDENCE
819	Second St				Main Ro	ad				ON A FARM?
3. NAME OF DECEASED {Type or print}	Fi Sodi		Middle		Tawes	4. DATE OF DEATH	_	onth uly	25	Year 1967
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8 C	ATE OF BIRTH		9. AGE (In year			UNDER 24 HRS
F	W	WIDOWED K			ay 16,18		last birthdoy)		Days I	Hours Min
10a. USUAL OCCUPATI during most of wor	ON (Give kind of work	done 10b. KIND	OF BUSINESS OR	NDUSTRY	11. BIRTHPLACE (SIG	ate or foreign	country)	12. CITI	ZEN OF	WHAT COUNTRY
	rking life, even if retired	Hous	ehold		Maryla	nd			USA	
13. FATHER'S NAME	7			1	4. MOTHER'S MAIDEN	NAME				
		ite			Amanda		White	_		
15. WAS DECEASEDEV	ER IN U. S. ARMED FOR (If yes, give wor or dotes of s	ervice		17. INFO				dra ecor		
	ATH [Enter only one co	210	ne	Mrs	Orville	LaCui	rts Poc	omoke	Cit	y MD
Conditions, if a gave rise to couse (a), stoting lying couse lost.	the under DUE TO	DITIONS CONTI	reodelle	a sut no	T RELATED TO THE TER	genera	Very Xea	IVEN IN PART	10	WAS AUTOPSY PERFORMED?
	AS UNDERLY® G ☐ G ☐ CAUSE OF DEATH / MEDICAL EXAMINER) RY Month, Doy, Ye 19	or 20d. INJURY		e. PLACE	OF INJURY (Home, for, street, office bldg., a	ırm. 120£ (Ci)		(Cc	ounty)	(State)
actual Signature	latended the suffy VS Charles W	1967.	er, M.D.	M.D.	curred avo 40	ADDRESS (S ket S)	m the causes street, city or town	and on the	ost saw e date	the deceased stated obave DATE SIGNED 7-26-6
NAME (Type) 220. BURIAL, CREMATIK REMOVAL (Specify LULIAL	ON, 226. DATE THEREO)F 22c.	NAME OF CEMETER Johns	RY OR CR			ITION (City, town, L Islan		M	(State)
22. FUNERAL DIRECTOR			ADDRESS ICESS Ani		24a. RE	SO BY REGIS		FISTRAR'S SIGN	NATURE	

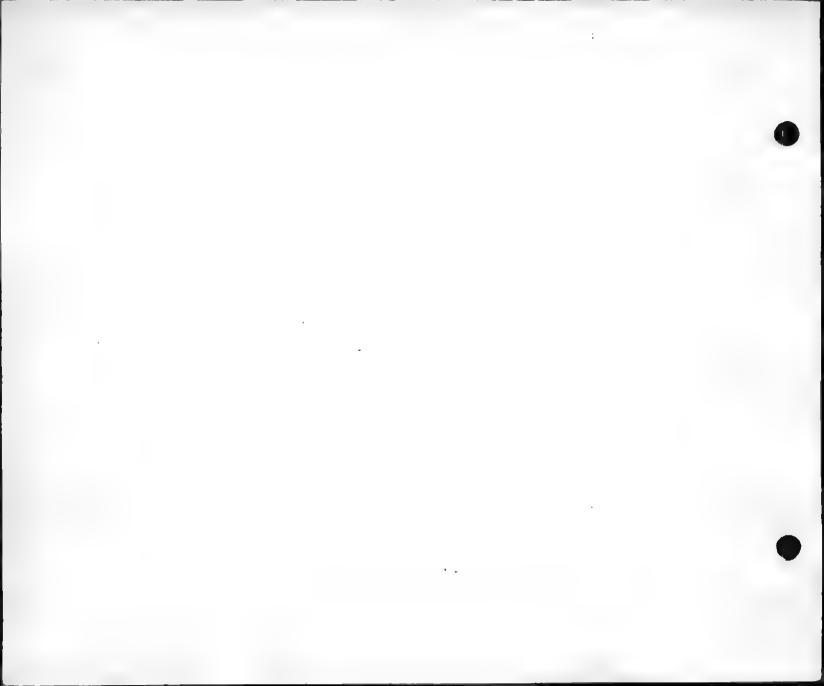
to an Omerone -

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY **b** COUNTY 2, onu PM3 Page Department of MARYLAND b. CITY OR TOWN (If autside carparate limits, KAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outs de carporate limits, write RURAL and give nearest tawn) d NAME OF HOSPITAL OR INSTITUTION (f not in hospital give street add e IS RESIDENCE Arth Form Showel ON A FARM 0 Give Poges Stote howe ofter deoth 3 NAME OF Middle 4 DATE Day DECEASED 0F (Type or ornt) 1965 DEATH to certificate, writing the word "pending in pendl in Item 18. Give should be forworded to the Chief Medicol Examiner's Office along 5 SEX 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLDR OR RACE 7. MARRIED NEVER MARRIED Saphday) Manths event within 72 hours ofter death WIDOWED DIVORCED 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT 100 USUA, OCCUPATION (Give kind of work done during host of warking te, even if retired INDUSTRY be executed within 24 permit. File pages 13 FATHER'S NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT (Yes no, or Joknown) (If yes give war or dates af service) 110 phonew 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)/ INTERVAL BETWEEN burial-frons,t ONSET AND DEATH PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) Stimate the certificate, writing the word This certificate should DUE TO any Thrombosis, anterior mesenteric artery 12-24 Conditions, if only, which gave (b) rise to immediate cause (a), .⊑ DUE TO 0 stating the underlying cause puo SD last be used 19 WAS AUTOPSY RERFJRMED? cremotion, or removal, PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART (a) CERT PICATION NO 2Dg EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) 3 should PRIMARY Or CONTRIBUTING EXAMINER: CAUSE OF DEATH 20¢ TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour a.m. factory, street, office bldg , etc.) may be retoined for your FUNERAL DIRECTOR: Page Not While Page at wark at work 21. I certify that I took charge of the remains described above, held an Autapsy Inspection Inquiry and in my opinion burial, deoth resulted from: Natural couses Accident [Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER 0 ACTU AL 22. DATE SIGNED 5 may be retr TO FUNERAL D Heafth prior t SIGNATURE the funeral NAME Type CREMATION (City or Town) 24 F 25g REC'D BY REGISTRAR VR A15ME (5) 6M 1/67

Item 18 Film 390 7-21-67 MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10337 MEDICAL EXAMINER'S CERTIFICATE OF 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o COUNTY o STATE b COIDNTY haurs after death MARYLAND delay c LENGTH OF STAY IN 1b nearest town) gud Departme P.M3. RURA OSP TAL OR INSTITUTION (finot in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? form YES NO K ate haurs after death 3 NAME OF Middle 4 DATE Year Manth Dov DECEASED OF DEATH DWNSEND 22 w.thin (Type or pnnt) AGE (In years FILNDER LYFAR DATE OF BRID IF LINDER 24 HRS 7 MARRIED NEVER MARR ED 1961 Months birtadoy) Hours WIDOWED DIVORCED event Office and 2 106 KIND OF BUSINESS OR B RTHPLA/E (State or foreign country) 12 CITIZEN OF WHAT BNDJSTR' 5 In any within 24 9110 cate, writing the ward "pending" in penal in be farwarded to the Chief Medical Examiner's pages 13 FATHER'S NAM 14. MOTHER'S MAIDEN NAM File IS WAS DECEASED EVER IN ITS ARMED FORCES? INFORMANI executed s a burial-transit permit crematian, ar remaval (Yes ano, or unknown). (If yes give wor or dates of service CAUSE OF DEATH (Enter only one couse per ne for (o), INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) This certificate should DITE TO self inplicated Conditions, flony, which gove rise to immediate couse (a) DUE TO stoting the underlying couse 0.0 last PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS ALTOPSY CERTIFICATION PERFORMED' please execute the certificate, 5 m pe priar 2Do EXTERNA CAJSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of inury in Port I or Port I of Iem 18) 3 shauld PRIMARY OF CONTRIBUTING Page 4 shauld MEDICAL EXAMINER: CAUSE OF DEATH its designated agent, 20c TME OF NJURY Month, Doy Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (County) (Stote) may be retained for your FUNERAL DIRECTOR: Page While foctory street, office bldg .etc.) NOR of work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my apinian the funeral director. Suicide X death resulted from: Natural causes Accident Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE O DEPUTY necessary, Health or **EXAMINER'S** NAME (Type 23b DAJE THEREO NAME, OF BURIAL, CREMATION (County) (State) 0 PBMOVAL (Specify) FUNERAL DIRECTOR 250 REC D BY REGISTRAR 24 2Sh REGISTRAR'S SIGNATURE VR A15ME (5) 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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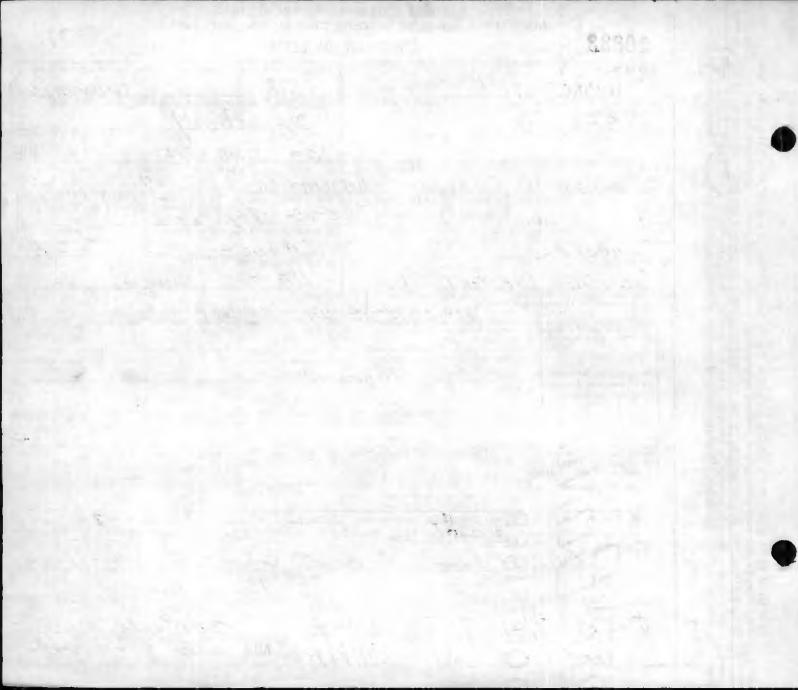
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate He exercised within 24 hours after death.	Page 4 may be retained by the haspital ar attending physician.		9	shauld be filed with the State Dept. of Health prior to burial, cremation, or remayol, and in any event within 72 hours after Death.
-	9	4	.=	
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\vdash		-		

VR A15 (4) 25M 1/67

MEDICAL CERTIFICATION

	10000	CERTIFICATE	OF DEATH		
	PLACE OF DEATH	yo .	2. USUAL RESIDENCE (When a. STATE)	e deceased lived, if institution: b. COUNTY	
	WORCESTER	MARYLAND	(111)		Wicomico
	b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside	carparate limits, write RURAL	and give nearest tawn)
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hos	anital aire street address)	d. STREET ADDRESS	DURY	a IS PESIDENCE
	L. MARIE OF HOSFILAE OK MISTITOTION (II HOSTIN NO.	spiral, give street address)	123 21	UD ST.	e. IS RESIDENCE ON A FARM? YES NO
	NAME OF First	Middle	Lost 4.	DATE Month	Day Year
	OFCEASED (Type or print) MERUIN Co.	Lumbus Wi	RIGHT SR.	OF DEATH	29 1967
5.	SEX 6. COLOR OR RACE 7. MA	RRIED NEVER MARRIED	8. DATE OF BIRTH		IF UNDER 1 YEAR IF UNDER 24 HRS.
	M Melorko WID	OWED DIVORCED	3-10-190.	7 60 yrs.	Manths Days Haurs Min.
	ng mast af warking life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Sto	ite, ar fareign caumtry)	12. CITIZEN OF WHAT COUNTRY?
13	FATHER'S NAME	-	14. MOTHER'S MAIDEN NAME	E., 1:10	4.3.7
10.	(-EAR/ - /110)	AUT SP	HATTI	- Baro	0
15.	WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17. I	NFORMANT	Address	<u> </u>
(Ye	s, no, or unknown) (If yes give war ar dates of service	218-05-8250 E	DNA WRI	OTHT SA	ALISBUEY MD
	18. CAUSE OF DEATH (Enter only one cause per l	line far (a), (b), and (c).)			INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Caranara.			ONSET AND DEATH
	M201 DUE TO				
	Canditians, if any, which gave 1 (b)	10 min			
	rise to immediate cause (a),				
	last. Stating the underlying cause (c)				
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU	UTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITI	ON GIVEN IN PART 1(a)	19. WAS AUTOPSY
VION					PERFORMED? YES NO
CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in Part	I ar Part II af item 18.)	
	OR CONTRIBUTING (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
MEDICAL	20c. TIME OF INJURY Manth, Day, Year		CE OF INJURY (Hame, farm,	20f. (City ar tawn)	(Caunty) (State)
ME	Haur'a.m. p.m. 19	While Nat While factor	ary, street, affice bldg., etc.)		
	21. I certify that (1) (this haspital)	attended the deceased fram_	7-29- 196	7, to 7-25	, 1967, that (I) (we) last
	saw the deceased alive an	291963, and that	t death accurred at 🏖	2. M, from causes on	nd an the date stated above.
	22a. SIGNATURE	P	ATTENDING - MED). STAFF	22b. DATE SIGNED
	Mas Pr	Lace M.C	D. PHYS. LAS DIRE	ECTOR L PHYS. L	72-31-67
	22c. PHYSICIAN'S NAME (Type)	h t	22d. ADDRESS Be	whin med	
230	. BURIAL, CREMATION, 23b. DATE THER GOF	23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City at Town)	(Caunty) (State)
	REMOVAL (Specify)	7 mtlalu	en	to with	e Miconic MI
24	. FUNERAL DIRECTOR	ADDRESS	2Sa. REC'D BY	REGISTRAR 25b. REGIS	STRAR'S SIGNATURE
1	flede & West	Raylor Mill 1	Chet 2 DATE AUG	2 1961 80	warles judges



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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	-						m				
	l.	PLACE OF DEATH	COUNTY h COUNTY						ore admission)		
			Worcester		MAR	YLAND	Mar	yland	D. (OC	Word	ester
	Г	b. CITY OR TOWN (I	f autside corporate limits	,	c. LENGTH OF STAY	IN 16	c. CITY OR TOWN (If or	rtside corparate	limits, write RL	JRAL and give near	est tawn)
	I	ocomoke	give negrest town)		29 year	S	Poc	omoke	City	12	31
in		d. NAME OF HOSPIT	AL OR INSTITUTION (If no	t in hospit <mark>al,</mark> g	give street address)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?
00	1	02 Ceda	r Street				902	Ceda	r Stre	et	YES NO
1	3.	NAME OF DECEASED	Fir	st	Middle		Last	4. DATE	Man	eth D	ay Year
)		(Type or print)	MARY		ELIZABET	H	YOUNG	OF DEATH	Ju:	ly 17	1967
1	S.	ZEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIE	D 🔲	8. DATE OF BIRTH	9.	AGE (In years	Months Days	
	-	emale	White	WIDOWED		D S	ept. 16,1	878	last birthday) Yrs.	monnis buy.	noors min.
	10c	USUAL OCCUPATION	(Give kind of wark done	10b. KI	ND OF BUSINESS OR DUSTRY		11. BIRTHPLACE (County		ign country)	12. CITIZEN	OF WHAT
		ng most of working. OUSEWIT	e	""			Delaw	are		COUNTRY	.A.
	1	FATHER'S NAME					14. MOTHER'S MAIDEN	NAME			
		ames La					Marth	a Sim	nons		
	15.	WAS DECEASED EVE s, no, or unknown)	R IN U.S. ARMED FORCES? (If yes give war ar dates a	Carviral	SOCIAL SECURITY NO.	2.5	NFORMANT		Adde		
		No		1	None	Ed	ward W. Y	oung,	Pocom	oke Cit	y, Md.
		18. CAUSE OF DE	ATH (Enter only one cause H WAS CAUSED BY:								NTERVAL BETWEEN
		17.1	IMMEDIATE CAUSE	(c) Cor	onary Oc	clus	sion			fe`	WSET AND DEATH
		Conditions, if ony,	DUE		Oper Ant.		7	0 . 1 .			
		rise ta immediat	cause (a),	(P) OOT O	and Athe	rose	scloersis lerosis	&Athe	eroscl	erosis	Mears
		stating the under	lying cause								4
				(t)	O DEATH DIT NOT DE	ATED TO 1	THE TERMINAL DISEASE CO	UDITION CIVEN	IN DADT I/o	1	VACATITOPSV C
1	CATION	TAKE III. QUILK SII			oma of Wa			NUMBER	IN TAKE I(U)	1	PERFORMED?
0	FICA	20a. ACCIDENT WAS				_	(Enter nature of injury in	Part I or Part	I of item 18 l		YES NO
	CERTIFIC	OR CONTRIBUTING (IF EITHER, NOTIFY)	CAUSE OF DEATH	200. 01	SCRIBE HOW HISOKI O	LCONNED.	ferres marate at milary m	rain rain yarr	in al nom 10.j		
	MEDICAL		RY Manth, Day, Year	20d. IN	UURY OCCURRED	20e. PLA	CE OF INJURY (Home, farn	n. 20f.	(City or town)	(County)	(State)
	AP ME	Haur 'a.n	19	While at war			ary, street, affice bldg., etc.				(/
		21 L certif	y that (I) (this has			fram	June	9 /10 to	Matr '	15 19 67	that (I) (we) las
		saw the de	ceased alive an_1	Jav 1	19_67	and that	death accurred at	7 PM.	fram causes	and an the do	ate stated abave
		220. SIGNATURE	1/1		0.		V		-	22b. DATE SIG	
		1.6	Savoru	2,	Av :	M.E	D. PHYS.	MED. DIRECTOR	3 STAFF C	July	19. 196
-1		22c. PHYSICIAN'S NAME (Type)		1	1		22d. ADDRESS .				
1		takant (14be)	N.E. Sarto	rius,	Jr., M.		114 Mai	rket S	t. Po	comoke	City Ma
	230	BURIAL, CREMATIO			23c. NAME OF CEM		CHEMATORYX	23d, LOC	ATION (City or To	own) (Coun	ty) (Stafe)
1		BUFI al	1	1967	First	Bap		Pocc	moke -	- Worce	ster-Md.
N.	E-24	FUNERAL DIRECTO			ADDRESS			BY REGISTRA	R 2Sb. R	EGISTRAR'S SIGNAT	URE
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